TOWN OF BROOKLINE
DEPARTMENT OF PUBLIC HEALTH
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Patrick J. Maloney RS, MPAH
Chief Environmental Health Service

Office Use Only:
Date Recv'd:
Amount Paid:
San Appr:
Chief Appr:

Check#:
Permit#:

APPLICATION FOR PERMIT/QUESTIONNAIRE

(PLEASE PRINT OR TYPE)

Check One: New _____ Renewal _____ Renovations/Menu Change_____

Name of Establishment: **Phone:**

_____

Location:_____

Name of Firm: **Phone:**

_____

Address of Firm:_____

Operator Name + mailing addresses:

_____

Company e-mail_____

I. Type of Business: Corporation: _____ Partnership: _____ Sole owner:_____

II. Type of Establishment: (Check all that apply)

Food Service		Catering	_____	Residential Kitchen	_____
-(Any food prep)	_____	Bed and Brkfst	_____	Temporary Food Service	_____
Retail					
- (Packaged foods)	_____	Bakery	_____	Mobile Food Establishment	_____
Limited Retail	_____	Daycare	_____	Common Victualler License	_____
- (Chips/candy only)		Nursing Home	_____	Food Vendor Service	_____

Corporate Officers Telephone #

President:_____ _____

Treasurer:_____ _____

Clerk:_____ _____

PLEASE SIGN BELOW

I, the undersigned certify under the penalties of perjury that the applicant has filed all state tax returns and paid all state taxes as required by law, (MGL Chap62C s 49A).

_____ _____ _____

Date of Application Signature Title

III. Seating Capacity: _____ IV. Size of Establishment (Square Footage): _____

V. Names and positions of Employees trained and certified in Choke-Saving technique and dates of Certification as on certificate: (required 25 seats or more).

_____

(If these employees are currently certified by the American Red Cross or other organization, copies must be attached.)

VI. Names of manager/supervisor certified in food safety:_____
Certification granted by (attach copies of certification)_____

VII. Name and address of Pest Control Company:_____
Frequency of Service: _____

VIII. Rubbish Removal Co._____
Frequency of Removal:_____

IX. Type of Food Sold/Or Produced: (check all that apply)

Reduced Oxygen Packaging/Sous Vide/vacuum packaging _____ Sushi_____ (Requires HACCP Plan)

Sushi Rice Testing Lab:_____

Shell Fish_____ Salad Bar _____ Tobacco Sales_____

Consumed on Premises_____ Take-out _____ Pre-Packaged _____

Frozen Dessert/yogurt/custard (from machine) _____

Frozen Dessert Testing Lab:_____

X. Menu: Attach a copy of your Menu. List menu items below if current menu not available.
Menu items must comply with Town of Brookline Article 8.28 Restriction on Use of Artificial Trans Fat, and display Consumer Advisory to inform consumers of risk of eating raw or undercooked foods.

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

XI. As required by MGL c 152 s 25A this Establishment is in compliance with the Massachusetts Worker Compensation Coverage Requirement (establishments not required to comply with the coverage requirements must submit copies of the Industrial Accidents affidavit form with this application).

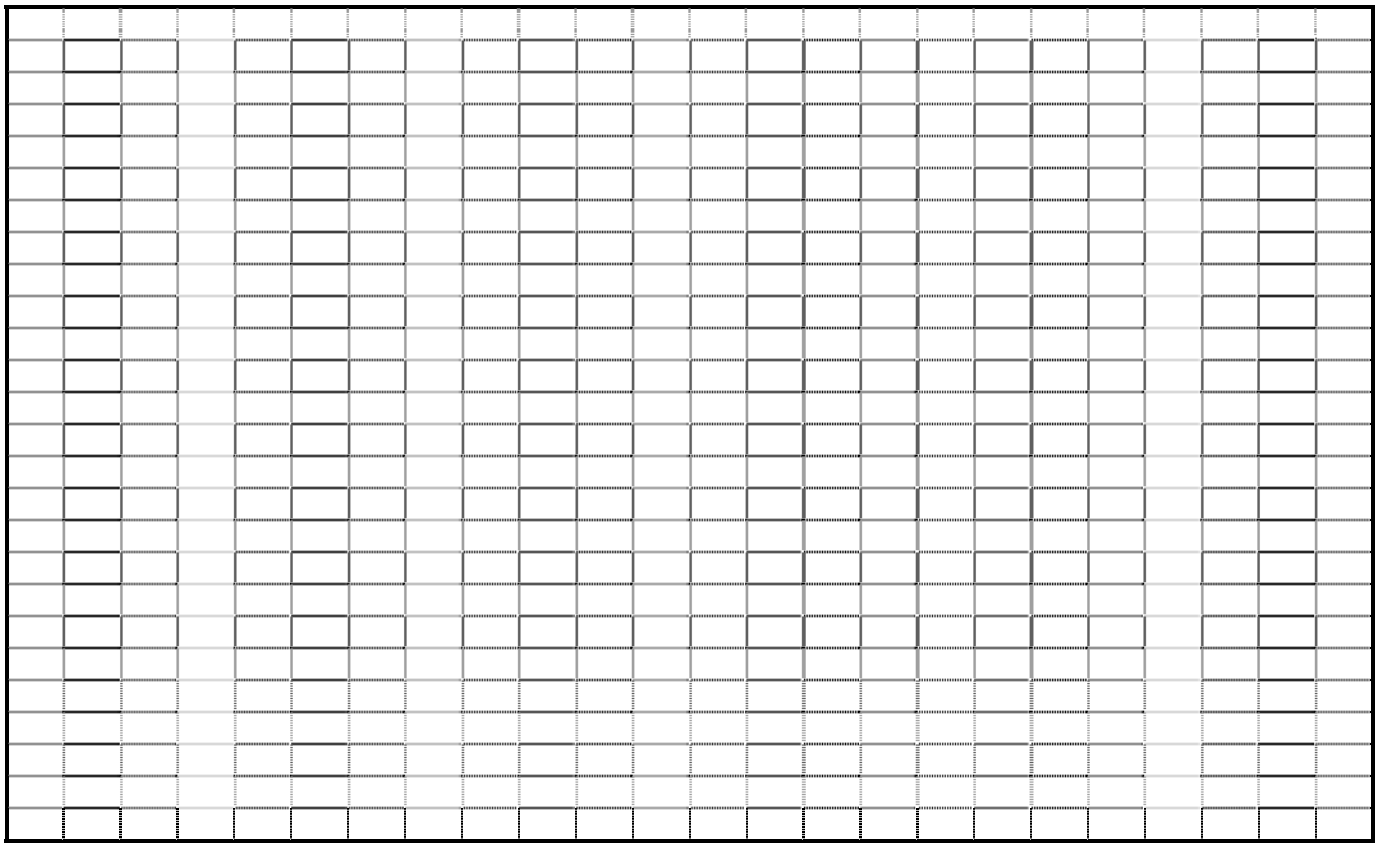
Yes:____ No:____

XII. Days and Hours of Operation: _____

XIII. Equipment: Submit Equipment Schedule and Specification Sheets. If not available, list all new and/or existing equipment in below list. All equipment must be commercial and have NSF, UL or other approved certification.

1 _____	**2**_____	**3**_____	**4**_____
5_____	**6**_____	**7**_____	**8**_____
9_____	**10**_____	**11**_____	**12**_____
13_____	**14**_____	**15**_____	**16**_____
17_____	**18**_____	**19**_____	**20**_____

XIV. **Floor Plan:** Provide a detailed floor plan indicating where above equipment is located. If professional drawings not available, sketch floor plan below using above numbers as a key for equipment.



Required Attachments:

- ☐ **Equipment Specification Sheets**
- ☐ **Floor Plan**
- ☐ **Certified Food Protection Manager** (Serve Safe or equivalent, where required)
- ☐ **Choke Saver Certificates** (required for 25 seats or more)
- ☐ **HACCP Plans** (For Sushi Rice, Vacuum Packaging, etc.)